VIRGINIA MEDICAID REQUEST FOR SERVICE AUTHORIZATION

DUR Medication

IBRANCE® (PALBOCICLIB)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Requests for service authorization (SA) must include patient name, Medicaid ID#, and drug name. Appropriate clinical information to support the request on the basis of medical necessity must be submitted. Please include all requested information; incomplete forms will delay the SA process. **SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.**

The completed form may be **FAXED TO 800-932-6651.** Requests may be phoned to 800-932-6648.

Requests may be mailed to: Magellan Medicaid Administration / 11013 W. Broad Street, Suite 500/ Glen Allen, VA 23060 / ATTN: MAP

Today's Date: ___ ___/___ ___/___ ___ ___ ___ Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION

Name: (Last, First) _____ **Medicaid ID#:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ __

Date of Birth: ___ ___/___ ___/___ ___ ___ ___ **Gender:** ☐ **Male** ☐ **Female**

DRUG INFORMATION

Drug Name/ Form: _____ **Strength:** _____
Dosing Frequency: _____ **Length of Therapy:** _____
Quantity per day: _____

DIAGNOSIS AND MEDICAL INFORMATION – Please Answer All Questions To Facilitate Processing

IBRANCE® - to receive a SIX (6) month approval for this drug, please complete the questions below.

Does the patient meet the following criteria?

- Diagnosis of advanced breast cancer ☐ Yes ☐ No
- With the following conditions:
  - Postmenopausal ☐ Yes ☐ No
  - Estrogen receptor (ER)-positive ☐ Yes ☐ No
  - Human epidermal growth factor receptor 2 (HER2)-negative ☐ Yes ☐ No
  - Used in combination with letrozole ☐ Yes ☐ No
- Is the medication being prescribed by an oncologist? ☐ Yes ☐ No
- Is the patient 18 years of age or older? ☐ Yes ☐ No

Medical necessity: Provide clinical evidence that support the use of the requested medication.

PRESCRIBER INFORMATION

Name/Specialty (print):_____ NPI Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Signature of Prescribing Provider: _____

PLEASE INCLUDE ALL REQUESTED INFORMATION
INCOMPLETE FORMS WILL DELAY THE SERVICE AUTHORIZATION PROCESS

FAX TO 800-932-6651
SERVICE AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE
http://www.virginiamedicaidpharmacyservices.com